Carriage Hill
Health & Rehab Center
Living made better

July 12, 2013

Wietske G Weigel-Delano
Long Term Care Supervisor
VDH Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233

Dear Ms. Delano:

Please find enclosed Carriage Hill Nursing and Rehabilitation's Plan of Correction with an alleged date of compliance of July 30, 2013 in response to the 2567 Survey Report generated after a standard survey ending June 21, 2013 and received by Carriage Hill on July 3, 2013.

Carriage Hill's submission of the enclosed Plan of Correction does not constitute an admission as to the accuracy of the deficiencies cited in the 2567; however, it does constitute Carriage Hill's good faith effort to demonstrate compliance with all conditions of participation both now and on an ongoing basis.

Sincerely,

John Sevier
Administrator

cc: file

RECEIVED
JUL 12 2013
VDH/OLC

6106 Health Center Lane • Fredericksburg, Virginia 22407
Phone 540.785.1120 • Fax 540.785.6201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495396	A. BUILDING _____ B. WING _____	C 06/21/2013

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CARRIAGE HILL HEALTH AND REHAB CENTER	6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 6/18/13 through 6/21/13. Complaints were investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 150 certified bed facility was 140 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #20) and 8 closed record reviews (Residents #21 through #28).

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F 156 SS=D — 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers

F 156

Resident #28's responsible party was contacted on July 1, 2013 regarding the ABN and right to appeal. Facility Business Office Manager reviewed the ABN and right to appeal with the resident's responsible party and mailed a copy via certified US mail. To date, it has not been returned.

Any resident whose Medicare qualifying skilled nursing and/or therapy services were discontinued has the potential to be affected. An audit of all residents who were discharged from Medicare qualifying skilled services in the last thirty (30) days will be completed and any area identified as non-compliant will be addressed.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — July 12, 2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

On July 1, 2013, Business Office and Social Services staff were educated on the Advanced Beneficiary Notice and the requirement that it be provided to each resident and/or responsible party prior to the discontinuation of Medicare qualifying services. Each ABN will be maintained in a book/binder in the Business Office.

A weekly audit (for a period of four weeks) and monthly audits (for a period of two months) of all Advanced Beneficiary Notices will be completed by the facility Administrator or designee. Any negative findings will be reviewed and discussed for further recommendation in the facility's quality assurance meetings.

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complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to provide one of 3 residents in the survey sample (Resident #28) with written notification of discontinuation of services (ABN- Advanced Beneficiary Notification) and her right to appeal prior to discharge from Medicare Services, prior to her discharge home from the facility on 6/4/13.

The findings include:

Clinical record review revealed, Resident #28 was a 90 year old female admitted to the facility on 4/5/13 with multiple diagnoses including high blood pressure, gastric reflux, hyperlipidemia

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(abnormal levels of fat/cholesterol in the blood), pulmonary embolism (blood clot in the lungs) and depressive disorder. Her discharge Minimum Data Set assessment dated 6/4/13 coded her score on the Brief Interview for Mental Status as 12 out of 15, indicating she had moderate cognitive impairment. She needed supervision with eating. She needed extensive assistance with bed mobility, transfers, dressing and personal hygiene.

A social services progress note dated 6/5/13 documented Resident #28 was discharged on 6/4/13 with her husband and daughter as planned.

On 6/20/13 at 11:40 AM, the administrator stated the facility staff did not have an ABN letter for Resident #28.

On 6/20/13 at 11:50 AM, the business office manager (BOM) stated she attempted to call the resident's responsible party. She said she left a message on the responsible party's phone to call her (BOM). The BOM stated the responsible party did not return the call. She said she did not have any notes regarding when the message was left. She also said she did not remember when the message was left.

On 6/21/13 at 12:30 PM, this concern was shared with the administrator, the director of nursing and the regional director. The administrator stated the facility did not have a policy regarding ABNs. He said the facility followed the Centers for Medicare and Medicaid Services guidelines.

The Notice of Medicare Provider Non-Coverage

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F 156	Continued From page 4 form documented "...You have the right to an immediate. independent medical review (appeal) of the decision to end Medicare coverage of these services...Your request for an immediate appeal should be made as soon as possible, but no later than noon on the day before the effective date indicated above..."	F 156		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to develop a care plan to address triggered areas on the Care Area Assessment (CAA) of the	F 279	F 279 **Resident #3's care plan was updated to address her impaired vision on June 19, 2013.** **Any resident whose CAA triggered for vision has the potential to have been affected. An audit of all comprehensive assessments within the last ninety (90) days will be completed to review all residents' who have triggered for vision impairment. Each resident's care plan will be reviewed to assure impaired vision is addressed when triggered.** **MDS personnel, Unit Managers and the interdisciplinary team will be in-serviced by the corporate Regional RAI Coordinator on addressing all CAAs appropriately when completing or updating resident care plans.** F 279 Continued on Next Page	

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MDS (minimum data set) assessment for one of 28 residents in the survey sample, Resident #3.

The significant change MDS assessment, with an assessment reference date of 1/23/13, under "Visual Function" on the CAA summary in the "Care Area Triggered" was checked with a check mark to indicate the decision was made to care plan the area of vision. The facility staff failed to develop a care plan to address Resident # 3's impaired vision.

The findings include:

Resident #3 was admitted to the facility on 2/23/12 with diagnoses that included but were not limited to: aphasia, muscle weakness, high blood pressure, stroke, depression, dysphagia, history of urinary tract infections, peripheral edema, urinary retention, osteoarthritis and hyperlipidemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, dated 4/19/13 coded the resident as having both short and long term memory problems. The resident was coded as being severely impaired to make cognitive daily decisions. Resident #3 was coded as requiring extensive assistance of one to two staff members for bed mobility, dressing and eating. She was totally dependent on the staff for transfers from one surface to another, toileting needs, personal hygiene and bathing. The resident was incontinent of both bowel and bladder. In Section B - Hearing, Speech and Vision, Resident #3 was coded as being highly

Random audits of CAAs will be conducted on a weekly basis for comprehensive assessments completed that week (for a period of eight weeks) by the MDS Nurse(s) or designee. Any CAA identified as not having been addressed on the Care Plan will be corrected. Results of care plan audits will be discussed for further recommendations during the facility's monthly Quality Assurance meeting.

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impaired to see in adequate light.

The significant change MDS (minimum data set) assessment, with an assessment reference date of 1/23/13, was reviewed. The "Care Area" for "Visual Function" had a check mark in Column A, indicating that it triggered as a care area. A check mark was documented in Column B, indicating the decision was made to plan the care area on the comprehensive care plan.

Review of the comprehensive care plan, initiated on 2/27/12 and revised on 5/4/13, did not reveal a care plan to address the resident's highly impaired vision.

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 6/19/13 at 2:25 p.m. When asked who is responsible for updating the care plans, LPN #3 stated, "The MDS staff, the unit managers and we (the nurses) can." When asked if a resident had impaired vision, would you expect to see if on the care plan, LPN #3 stated, "Yes, I would believe so."

An interview was conducted with LPN #8 on 6/19/13 at 2:35 p.m. When asked who is responsible to ensure the care plans are developed, LPN #8 stated, "The whole team ensures they are up to date, the MDS staff develops the care plan based on the assessments."

The administrative team was made aware of these findings on 6/19/13 at 5:08 p.m. A request was made for the policy on developing care plans when it triggers on the CAA Summary.

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The RAI Manual documented, ""Section V: Care Area Assessment: V0200. CAAs and Care Planning
1. Check column A if care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (resident assessment instrument) [MDS and CAA(s)]. Check column B if the triggered care area is addressed in the care plan.
A second request for the policy on care plans was again requested at the end of the day meeting on 6/20/13 at 6:35 p.m.

A third request for the policy on care plans was requested from the director of nursing on 6/21/13 at 8:12 a.m.

On 6/21/13 at 8:47 a.m., the administrator informed this surveyor that the facility uses the RAI (resident assessment instrument) manual to complete the care plans.

On 6/21/13 at 9:30 a.m. the assistant administrator presented a copy, taken from the RAI manual, of "The Care Area Assessment (CAA) Process and Care Plan Completion."

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS F 281

The services provided or arranged by the facility must meet professional standards of quality.

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review, and staff interview the facility staff failed to follow professional standards for clarifying physician ' s orders for one of 28 sampled residents (resident # 2).

For Resident #2, the facility staff failed to clarify a physician's order for Valproic Acid levels and Ammonia levels.

The findings include:

Resident #2 was most recently admitted to the facility on 12/2/12 with the diagnosis of but not limited to Parkinson's, psychosis, bipolar, diabetes, chronic kidney disease, high blood pressure, and acute renal failure. The most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/13. Resident #2 was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total assistance from staff for bathing; extensive assistance from staff for transfers, ambulation, dressing, eating, and hygiene; and was frequently incontinent of bowel and bladder.

A review of the clinical record revealed the most recent POS (Physician's Order Sheet), signed by the physician on 6/3/13, contained the following orders:

CMP*, CBC**, HGBA1C**, Valproic Acid Level** every three months (Dec-Mar-June-Sept). This

A clarification order for Resident #2's physician's order for Valproic Acid and Ammonia levels was obtained June 20, 2013.

Any resident who has a physician's order for lab work to be obtained has the potential to be affected. An audit of all physician ordered lab work will be completed and any area of non-compliance will be corrected.

Licensed nurses will be educated on obtaining clarification orders when physician ordered lab work does not clearly define the frequency or time period labs are to be drawn.

Any new physician orders for lab work will be reviewed daily (five days a week for a period of four weeks) by the Unit Manager or designee. A monthly audit will be completed during order reconciliation to determine if there are any lab orders requiring clarifications. Any areas identified as non-compliant will be corrected immediately. Results of these audits will be discussed for further recommendations during the facility's monthly quality assurance meetings.

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order was dated 11/15/11.

Valproic acid and Ammonia** levels every four to six weeks. This order was dated 2/26/13. This order was based on recommendation by the resident's psychiatrist. The resident visited the psychiatrist and obtained the recommendation on 2/26/13.

Further review of the clinical record revealed for the Ammonia level there was no evidence of a clarification order to identify a specific frequency.

Continued review of the clinical record revealed for the Valproic Acid level there was no evidence of the facility staff obtaining clarification of the conflicting orders for Valproic Acid levels.

On 6/20/13 at 8:45 a.m., an interview was conducted with LPN #1 (Licensed Practical Nurse #1, the unit manager). Regarding the conflicting Valproic Acid level orders and how often should it be obtained, she stated, "It should have been clarified. It was an oversight." Regarding the Ammonia levels, she stated, "Clarification should have been done to determine how often it needed to be done."

A review of the facility policy for "Orders" failed to reveal any process for clarifying conflicting, confusing, or vague orders.

On 6/20/13 at the end of day meeting at 6:23 p.m., the Administrator, Assistant Administrator, Director of Nursing, and Corporate Nurse Consultant, were made aware of the findings.

In "Fundamentals of Nursing" 6th edition, 2005;

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Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary"

*A CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques. Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405.

**The following was obtained from http://www.nlm.nih.gov/medlineplus/

A comprehensive metabolic panel (CMP) is a group of chemical tests performed on the blood serum (the part of blood that doesn't contain cells). These tests include total cholesterol, total protein, and various electrolytes. Electrolytes in the body include sodium, potassium, chlorine, and many others. The rest of the tests measure chemicals that reflect liver and kidney function. This test helps provide information about your body's metabolism. It gives your doctor information about how your kidneys and liver are working, and can be used to evaluate blood sugar, cholesterol, and calcium levels, among other things. This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/ency/article/

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HbA1c is a test that measures the amount of glycated hemoglobin in your blood. It is used to measure your blood sugar control over several months. It can give a good estimate of how well you have managed your diabetes over the last 2 or 3 months. Website: http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm

Therapeutic drug levels are laboratory tests to look for the presence and the amount of specific drugs in the blood....The Valproic acid: 50 to 100 mcg/mL. "
Wesbite:
http://www.nlm.nih.gov/medlineplus/ency/article/003430.htm

The ammonia test measures the amount of ammonia in a blood sample....The normal range is 15 - 45 micrograms per deciliter (mcg/dL)."
Website:
http://www.nlm.nih.gov/medlineplus/ency/article/003506.htm

F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F 309	

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Resident #9's attending physician was notified regarding the facility's failure to hold the physician ordered medication when her blood pressures warranted doing so. Resident #9 had no negative outcome related to the medication being administered.

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This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow physician's orders for four of 28 residents in the survey sample, Residents #9, #16, #18, and Resident #15.

1. The facility staff failed to follow the physician's order to hold the medication Carvedilol (used to treat high blood pressure *) for a systolic blood pressure less than 110 on multiple occasions from January 2013 through June 2013 for Resident #9.

2. Facility staff failed to follow the physician's order to hold the medications Metoprolol (used to treat high blood pressure *) and Norvasc (used to treat high blood pressure **) for systolic blood pressures less than 110 for Resident #16.

3. Resident #18's as needed clonidine (used to treat high blood pressure *) was not administered for systolic blood pressure (SBP top number in a blood pressure reading) greater than 140 or diastolic blood pressure (DBP-the lower number in a blood pressure reading) greater than 90 as the physician ordered. Resident #18's physician was not notified for a SBP greater than 140 as the physician ordered.

4. The facility staff failed to ensure the wound treatment around the supra pubic catheter was completed as ordered for Resident #15.

Resident #16's attending physician was notified regarding the facility's failure to hold the physician ordered medication when her blood pressures warranted doing so. Resident #16 had no negative outcome related to the medication being administered.

Resident #18's attending physician was notified regarding the failure to administer the medication when his blood pressures warranted doing so. Resident #18 had no negative outcome related to the medication being administered.

Resident #15's attending physician was notified of the instances in which the wound treatment was not documented as completed. Resident #15's affected area was resolved on April 24, 2013 and treatment was discontinued.

Any resident who receives antihypertensive medications with blood pressure parameters has the potential to be affected. A review of all current residents with orders for blood pressure parameters will be completed and any identified area of non-compliance will be corrected.

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The findings include:

1. Resident #9 was admitted to the facility on 11/29/12 and readmitted to the facility on 1/24/13 with diagnoses that included but were not limited to: stroke, diabetes, dementia, ischemic heart disease and high blood pressure.

Resident #9's most recent MDS (minimum data set), a significant change in status assessment, with an ARD (assessment reference date) of 4/8/13 coded the resident's cognition as being severely impaired.

Review of Resident #9's clinical record revealed a physician's order, dated 1/3/13 for Carvedilol 3.125mg (milligrams) twice daily- hold for SBP (systolic blood pressure) < (less than) 110 or HR (heart rate) <55.

Review of Resident # 9's MARs (medication administration records) for the months of January 2013 through June 2013 revealed the Carvedilol was administered to Resident #9 (as indicated by a check mark and initials) on the following dates when her systolic blood pressure was less than 110.

- 1/4/13 at 9:00 a.m.- SBP: 104
- 1/5/13 at 9:00 p.m.- SBP: 103
- 1/29/13 at 9:00 a.m.- SBP: 100
- 2/5/13 at 9:00 p.m.- SBP: 108
- 2/6/13 at 9:00 a.m.- SBP: 103
- 2/7/13 at 9:00 a.m.- SBP: 108
- 2/10/13 at 9:00 a.m.- SBP: 106
- 2/14/13 at 9:00 a.m.- SBP: 104
- 2/15/13 at 9:00 p.m.- SBP: 104
- 2/17/13 at 9:00 a.m.- SBP: 80

Any resident with a physician ordered wound treatment has the potential to be affected. A review of all Treatment Records (TAR) for thirty days will be completed. Any areas identified as non-compliant will be addressed immediately.

Licensed Nurses will be educated on medication administration relating to blood pressure parameters. Licensed Nurses will be educated on assuring all wound treatments are completed and documented as so in the resident's treatment record.

The Director of Nursing or designee(s) will audit medication administration relating to blood pressure parameters daily (five times a week for a period of four weeks), weekly (for a period of four weeks) and monthly thereafter.

The Director of Nursing or designee(s) will audit resident treatment records daily (five times a week for a period of four weeks), weekly (for a period of four weeks) and monthly thereafter.

Results of the audits will be submitted to the facility Quality Assurance committee to be analyzed and discussed for further recommendations.

Completion Date: July 30, 2013

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- 2/22/13 at 9:00 p.m.- SBP: 108
- 2/27/13 at 9:00 a.m.- SBP: 101
- 2/28/13 at 9:00 a.m.- SBP: 108
- 3/2/13 at 9:00 a.m.- SBP: 109
- 3/12/13 at 9:00 a.m.- SBP: 107
- 3/16/13 at 9:00 a.m.- SBP: 103
- 3/20/13 at 9:00 a.m.- SBP: 107
- 3/21/13 at 9:00 a.m.- SBP: 101
- 3/26/13 at 9:00 a.m.- SBP: 101
- 3/28/13 at 9:00 a.m.- SBP: 100
- 3/31/13 at 9:00 a.m.- SBP: 108
- 4/10/13 at 9:00 a.m.- SBP: 108
- 4/11/13 at 9:00 a.m.- SBP: 101
- 4/13/13 at 9:00 a.m.- SBP: 109
- 4/17/13 at 9:00 a.m.- SBP: 106
- 4/20/13 at 9:00 a.m.- SBP: 93
- 4/21/13 at 9:00 a.m.- SBP: 96
- 4/24/13 at 9:00 a.m.- SBP: 102
- 4/27/13 at 9:00 a.m.- SBP: 108
- 4/29/13 at 9:00 a.m.- SBP: 95
- 5/1/13 at 9:00 a.m.- SBP: 100
- 5/2/13 at 9:00 a.m.- SBP: 95
- 5/11/13 at 9:00 a.m.- SBP: 94
- 5/11/13 at 9:00 p.m.- SBP: 109
- 5/15/13 at 9:00 a.m.- SBP: 102
- 5/16/13 at 9:00 a.m.- SBP: 96
- 5/17/13 at 9:00 a.m.- SBP: 103
- 5/25/13 at 9:00 a.m.- SBP: 109
- 5/29/13 at 9:00 a.m.- SBP: 98
- 5/31/13 at 9:00 a.m.- SBP: 105
- 6/1/13 at 9:00 a.m.- SBP: 108
- 6/1/13 at 9:00 p.m.- SBP: 101
- 6/7/13 at 9:00 a.m.- SBP: 101
- 6/14/13 at 8:00 a.m.- SBP: 94

A nurse's note dated 1/5/13 at 11:03 a.m. documented, "Resident was being transferred from w/c (wheelchair) to toilet by CNA (certified

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nurse's aide) resident became light heade [sic] eyes rolled back of head. Resident was clammy. Resident put back to bed. Resident sits up starts talking like nothing ever happened. Vitals taken BP (blood pressure)- 98/64, P (pulse)- 83, sats (oxygen saturation) 94%, BS (blood sugar) 217 Nursing superviser [sic] made aware, MD (medical doctor) paged, RP (responsible party) made aware."

A nurse's note dated 1/5/13 at 1:00 p.m. documented, "Md called back he was made aware that the above resident got light headed while transferring to toilet. MD also made aware of vital signs."

A nurse's note dated 1/7/13 at 5:32 p.m. documented, "Pt (patient) alert and oriented x (times) 2, pt needs assistance with ADLs (Activities of Daily Living), pt had no c/o (complaint of) pain or discomfort, pt propels self in w/c, pt had episode of dizziness BP 76/58, MD assessed pt, pt had large cup of strawberry ice cream that her daughter brought in, pt finished all of it, pt resting in bed comfortable, pt stated she feels better no more dizziness, RP is aware of pt's change in condition."

On 6/19/13 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated administration of a medication is documented on the MAR with initials and a check mark. LPN #8 reviewed the January 2013 MAR (particularly 1/4/13, 1/5/13 and 1/29/13) and stated, "It's shown as it (the Carvedilol) is given."

Resident #9's comprehensive care plan initiated on 12/3/12 documented, "Focus: (name of

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resident) has altered cardiovascular status r/t (related to) Hypertension (high blood pressure), AFib (atrial fibrillation), ischemic Cardiomyapathy [sic] (s/p [status/post] defibrillator) ...Interventions: Medications per MD (medical doctor) order. Vital Signs per MD orders. Notify physician of any abnormal readings ..."

On 6/19/13 at approximately 5:15 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the above findings.

On 6/20/13 at 1:40 p.m., an interview was conducted with ASM #4, Resident #9's physician, regarding the use of Carvedilol. ASM #4 stated he prescribed the Carvedilol to Resident #9 for ischemic heart disease. ASM #4 stated he was aware of Resident #9 having low blood pressures but the benefits of the medication for ischemic heart disease outweighed the low blood pressures and the low blood pressures could be treated with fluids. ASM #4 stated this is why he ordered the parameters to hold the medication if the resident's systolic blood pressure was less than 110 or heart rate was less than 55. ASM #4 stated the Carvedilol should not have been administered when Resident #9's blood pressure was less than 110.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

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No further information was presented prior to exit.
Drug Reference:

*Carvedilol is used to treat high blood pressure and heart failure. This information was obtained from the Complete Guide to Prescription & Nonprescription Drugs; Griffith and Moore, 2011; Pages 182 & 877.

2. Resident #16 was admitted to the facility on 2/19/13 with a readmission of 3/9/13. Diagnoses included but were not limited to: hypertension, pneumonia asthma, perforation of intestine, difficulty walking, muscle weakness, hypothyroidism and left clavicle fracture.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/22/13, coded the resident as being cognitively intact for making daily decisions. The resident was coded as being independent to requiring extensive assistance of one staff member for all of her activities of daily living. Resident #16 was coded as being frequently incontinent bowel and bladder.

Review of the "Physician's Order Sheet" dated March 2013 documented, "Metoprolol Succinate ER (extended release) 50 MG (milligram) tablet Extended Release 24 Hours Oral (by mouth) 1x/day (one time per day), Everyday, 0800 (8:00 a.m.); 1 p.o. (by mouth) daily Hold for sbp (systolic blood pressure) < (less than) 110 Hold for pulse < 65. Start date 2/20/13."

The "Physician's Order Sheet" dated April 2013 through May 2013 documented, "Metoprolol Succinate ER 50 MG tablet Extended Release 24

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Hours Oral (by mouth) 1x/day. Every day, 0800 (8:00 a.m.); 1 p.o. daily Hold for sbp < 110 Hold for pulse < 55. Start date 3/11/13."

Review of the "Physician's Order Sheet" dated February 2013 documented, "Amlodipine Besylate (Norvasc) 5 MG Tablet Oral (By mouth) - 1x/day Everyday, 0800 (9:00 a.m.); 1 p.o (by mouth) Hold for sbp < 110. Start date 2/20/13."

Review of the "Physician's Order Sheet" dated April 2013 through May 2013 documented, "Norvasc (Amlodipine Besylate) 2.5 MG Tablet Oral (By mouth) - 1x/day Everyday, 0900 (9:00 a.m.); 1 tab (tablet) p.o qd (everyday), hold for sbp < 110. Start date 3/11/13."

Review of the MAR (medication administration record) dated February 2013 through March 10, revealed on 3/9 Metoprolol Succinate was administered with a documented systolic blood pressure below 110. Resident #16's blood pressure was documented as 106/55.

Review of the MAR dated May 2013 documented Metoprolol Succinate was administered with documented systolic blood pressures below 110:
5/20 - blood pressure 106/42
5/21 - blood pressure 104/42
5/24 - blood pressure 109/55
5/25 - blood pressure 108/56

Further review of the May 2013 MAR documented on the following dates Norvasc (Amlodipine Besylate) was administered with documented systolic blood pressures below 110:
5/20 - blood pressure 106/42
5/21 - blood pressure 104/42

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5/24 - blood pressure 109/55
5/25 - blood pressure 108/56

The MAR dated June 2013 revealed on the following dates Metoprolol Succinate was administered with documented systolic blood pressures below 110:
6/5 - blood pressure 106/52
6/10 - blood pressure 109/55
6/11 - blood pressure 108/57
6/13 - blood pressure 98/55

Further review of the June 2013 MAR documented on the following dates Norvasc (Amlodipine Besylate) was administered with documented systolic blood pressures below 110:
6/5 - blood pressure 102/56
6/10 - blood pressure 109/55
6/11 - blood pressure 108/57
6/13 - blood pressure 98/55

Review of Resident #16's current care plan dated 6/11/13 documented, "Focus: (Resident #16) at risk for variant reading in her blood pressure, hx (history of) stroke r/t (related to) her diagnosis of hypertension." Under the heading "Interventions" it documented, "Give anti hypertensive medications as ordered."

The Administrator and Director of Nursing were made aware of these findings on 6/20/13 at approximately 6:20 p.m. A request was made for a copy of the facility's drug reference, "Prentice Hall Nurse's Drug Guide 2007" for the medication metoprolol. When the copy was received, it was unreadable.

No further information was provided prior to exit.

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Drug Reference:
*Metoprolol - "Treatment of hypertension and angina pectoris; prevention of myocardial infarction, atrial fibrillation." Taken from "Drug Information Handbook for Nursing 2007, 8th Edition. Beatrice B. Turkoski, RN PhD; Brenda R. Lance, RN, MSN; Mark F. Bonfiglio BS, PharmD, RPh. p. 813
**Norvasc (Amlodipine) - "Reduces systolic, diastolic and mean arterial blood pressure." Taken from the facility's drug reference "Prentice Hall Nurse's Drug Guide 2007", Wilson, Shannon, Shields, Stang. p. 77

3. Clinical record review revealed, Resident #18 was a 70 year old male admitted to the facility on 4/17/13 with multiple diagnoses including high blood pressure, end stage kidney disease with dialysis, congestive heart failure (the heart can no longer pump enough blood to the rest of the body), anemia, gout and angina (heart pain). His 30 day Minimum Data Set assessment dated 5/14/13 coded the resident as able to make himself understood and able to understand others. His score on the Brief Interview for Mental Status was 13 out of 15, indicating he had no cognitive impairment. He ate with supervision only. He needed limited staff assistance for all other activities for daily living.

A physician's order written on 4/17/13 documented Resident # 18's blood pressure should be taken every shift, and if the SBP was greater than 140 or the DBP were greater than 90 give 0.1 mg clonidine* every 4 hours as needed.

A physician's telephone order dated 5/23/13

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documented to notify him if the resident's SBP was greater than 140.

Review of the Medication Administration Record (MAR) and the nurse's notes revealed the following:

On 6/8/13 (night), 6/11/13 (day, evening and night), 6/12/13 (evening and night), 6/13/13 (day), 6/14/13 (evening and night), 6/15/13 (day), 6/17/13 (day and night) and 6/19/13 (day and evening), the resident's SBP was above 140. Clonidine was administered; however, the physician was not notified as ordered.

On 6/7/13 (day shift), 6/9/13 (evening shift), 6/10/13 (day and evening), 6/12/13 (day), 6/13/13 (evening and night), 6/15/13 (day and evening), 6/16/13 (day, evening, and night), 6/17/13 (evening), 6/18/13 (day, evening, and night) and 6/20/13 (day), the resident's blood pressure was above the physician ordered parameters. The clonidine was not given as ordered and the physician was not notified of the SBP above 140.

On 6/21/13 at 5:55 PM, the unit manager Licensed Practical Nurse (LPN) #8 stated she would review the vital signs and the nurse's notes to see if she could reconcile when the clonidine should have been given. LPN #8 did not provide any further information prior to the end of the survey.

On 6/20/13 at approximately 5:30 PM, the resident's physician Administrative Staff Member (ASM) #7 stated Resident #18's BP was difficult to control. He stated the facility staff needed to give the clonidine and let him know. He stated if

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the clonidine was used more than 3 or 4 times the facility staff should call him and he would adjust the resident's medication. He stated he wanted to be notified. He stated the SBP was the most important (number). He stated if they reported at least 2 times in a shift he would adjust the dose. He said he had not had many calls regarding Resident #18 except for 2 or 3 weeks ago, when he changed the dose. ASM #7 stated he was not notified of the BP recorded on 6/19/13 (173/111) or 6/20/13 (159/92). He said he cannot remember everything about every patient.

On 6/20/13 at 6:55 PM, these concerns were shared with the administrator, the director of nursing (DON) the assistant director of nursing and the assistant administrator.

On 6/21/13 at 12:30 PM, this concern was shared with the administrator, the director of nursing (DON) and the regional director. The DON stated once the BP was taken the clonidine should have been administered. The DON stated the facility staff should have called the physician after the resident's SBP was greater than 140.

Drug reference:
* This information was obtained from the website: http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682243.html

4. Resident #15 was admitted to the facility on 12/7/12 with diagnoses that included but were not limited to: Bronchopneumonia, urinary tract infections, atherosclerosis, congestive heart failure, muscle weakness, chronic bronchitis,

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atrial fibrillation, diabetes, high blood pressure, peripheral vascular disease, bipolar disease, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 6/12/13, coded the resident as being cognitively intact to make daily decisions. The resident was capable of making himself understood and understanding others. Resident #15 was coded as requiring extensive assistance of one or two staff member for moving in the bed, transfers, toileting needs, and personal hygiene. Resident #15 was coded as requiring limited assistance of one staff member for moving on and off the unit and dressing. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter. The resident was coded in Section M - Skin as being at risk for developing pressure ulcers.

An interview was conducted with the resident on 6/20/13 at 11:30 a.m. Resident # 15 stated that the staff had not been doing his catheter care but they are getting better at it now. When asked to explain, Resident #15 stated, "A few months ago, the staff was not doing the catheter care. Now they perform the dressing before I get out of the bed."

Review of the physician orders for February 2013 documented, "Cleanse wound located around ostomy site (supra pubic) with NLS (normal saline), pat dry, apply Aquacel Ag, then cover with 4x4 Aquacel foam*. Change QD (every day) and

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prn (as needed) every day. *Aquacel foam dressing is a foam dressing with a silver absorbing agent in the dressing.

The review of the TAR for February 2013 did not reveal a nurse's signature on 2/18/13. There was no nursing note related to the resident's wound care on 2/18/13.

A physician order was written 2/21/13, that documented, "Apply zinc ointment to area superior to suprapubic catheter Q (every) shift and prn (as needed) until resolved."

A review of the TAR for February 2013 did not reveal a nurse's signature on 2/25/13 on the evening shift. There was no nurse's note on 2/25/13.

The physician orders for March 2013 documented, "Apply zinc ointment to area superior to supra pubic catheter Q shift and prn till resolved; 2x/day (twice a day)."

A second physician order dated, 3/25/13, documented, "Cleanse around suprapubic cath (catheter) with wound cleanser. Pat dry, apply zinc barrier oint (ointment). Cover with Aquacel foam dressing; change daily and prn."

The review of the March 2013 TAR revealed no documented nurse's signature on the day shift for 3/4/13, 3/14/13, 3/15/13, 3/19/13, and 3/24/13. There was no documentation on the evening shift on 3/3/13 and 3/4/13. The new order on 3/25/13 was not documented as done on 3/27/13. There were no nursing notes for 3/4/13, 3/14/13, 3/15/13, 3/24/13 and 3/27/13. The nurse's note

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for 3/19/13 documented the resident was on antibiotics for a urinary tract infection.

A new physician order dated, 4/10/13, documented, "Cleanse supra-pubic wound with normal saline, pat dry, apply bacitracin 500 gm (grams)/unit and zinc barrier ointment to wound bed, cover with Aquacel foam dressing Q day and prn."
The April 2013 TAR documented no nurse's signature on 4/12/13, 4/15/13, 4/18/13 and 4/21/13. There were no nurse's notes on 4/12/13, 4/15/13, 4/18/13 or 4/21/13.

A new physician order dated, 4/29/13, documented, "Cleanse around supra pubic with NS (normal saline), pat dry apply zinc barrier ointment and cover with Aquacel foam, change daily and prn."
The May 2013 TAR documented no nurse's signature on night shift on 5/10/13 and 5/21/13. There were no nurse's notes for 5/10/13 or 5/21/13.

The comprehensive care plan dated, 12/11/12 and revised on 3/22/13, documented, "(Resident #15) has actual decline in skin integrity r/t (related to) Stage I and Stage II to left and right buttock." The "Goals" documented, "(Resident #15) actual wound to supra. (suprapubic) cath site." The "Interventions" documented, "Care for supra pubic per MD orders. Treatment per MD orders."

The Wound Care Specialist notes were reviewed and revealed the following documented entries:
- 1/1/13, "Wound of abdomen: 0.5 x 1 x 0.1 cm (centimeters)...Initial evaluation. Drain tube laying against pannus (tissue layer). Tape tube to

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offload area."
- 1/15/13, "Wound of abdomen: 0.5 x 1 x 0.1 cm. Urostomy site improved."
- 1/21/13, "Wound of abdomen: 0.5 x 0.5 x 0.1 cm: Wound progress: stable."
- 2/5/13, "Anatomic location of previous existing wound examined today: Resolved on 2/5/13."
- 2/20/13, "Wound of Medial Pubis: 1.0 x 0.4 x not measurable cm.
- 2/27/13, "Wound of Medial Pubis: 1.0 x 0.4 x not measurable, cm. Wound progress: Improved.
- 3/13/13, "1.0 x 0.4 x not measurable cm. Wound progress: stable. May repeat wound cx (culture) next week if not improving."
- 3/27/13, "Wound: 1.0 x 0.4 x not measurable cm. Exudate: light sero-sanguious. Avoid catheter tugging on skin."
- 4/3/13, "Wound: 1.0 x 0.4 x not measurable cm. Exudate: light Sero-sanguinous. Additional information: Avoid Catheter tugging on skin. Add Bacitracin to barrier cream, less periwound irritation."
- 4/10/13, "Wound: 1.0 x 0.4 x not measurable cm. Exudate: light sero-sanguinous. Avoid catheter tugging on skin. Periwound irritation. Wound progress: Stable."
- 4/24/13, documented, "Wound of Medial Pubis; Resolved on 4/24/13."

An interview was conducted with LPN #13 on 6/20/13, when asked if there is no signature of a nurse on a treatment, what does it indicate, LPN #13 stated, "If it's blank, it means if not documented, it's not done."

The administrative team was made aware of these findings on 6/20/13 at 6:35 p.m. A policy on following physician orders was requested at this

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F 309	Continued From page 27 time. An interview was conducted with the director of nursing, administrative staff member (ASM) #2, on 6/21/13 at 8:12 a.m. When asked if a blank is discovered on the TAR, what does that indicate, ASM #2 stated, "If it's not documented it's not done." No further information was provided prior to exit. (1) This information obtained from the following website: http://www.convatec.com/wound-skin/aquacel%c2%ae-foam-dressing.aspx	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure appropriate treatment and services for care of a catheter was provided as ordered to prevent infection for one of 28 residents in the survey sample, Resident #15.	F 315	F 315 **Resident #15's attending physician was notified of the occasions in which the facility did not document the provision of catheter care. No new orders were received at that time.** **Any resident who requires catheter care has the potential to be affected. An audit of residents receiving catheter care in the last thirty (30) days will be completed. Any area identified as non-compliant relating to catheter care will be addressed appropriately.** **Licensed nurses and certified nursing assistants will be educated on providing catheter care and documenting accordingly.** F 315 Continued on Next Page	

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Facility staff failed to provide catheter care as ordered by the physician for Resident # 15 on multiple occasions from January through June 2013.

The findings include:

Resident #15 was admitted to the facility on 12/7/12 with diagnoses that included but were not limited to: Bronchopneumonia, urinary tract infections, atherosclerosis, congestive heart failure, muscle weakness, chronic bronchitis, atrial fibrillation, diabetes, high blood pressure, peripheral vascular disease, bipolar disease, and gastroesophageal reflux disease.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 6/12/13, coded the resident as being cognitively intact to make daily decisions. The resident was capable of making himself understood and understanding others. Resident #15 was coded as requiring extensive assistance of one or two staff member for moving in the bed, transfers, toileting needs, and personal hygiene. Resident #15 was coded as requiring limited assistance of one staff member for moving on and off the unit and dressing. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter. The resident was coded in Section M - Skin as being at risk for developing pressure ulcers.

The Director of Nursing or designee(s) will audit documentation of catheter care daily (five times a week for a period of four weeks), weekly (for a period of four weeks) and monthly (for a period of one month). Facility Clinical Educator will randomly observe catheter care on a weekly basis (for a period of eight weeks). Any area of non-compliance will be corrected. Findings of catheter care audits will be reviewed for further recommendations during the facility's monthly Quality Assurance process.

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An interview was conducted with the resident on 6/20/13 at 11:30 a.m. Resident # 15 stated that the staff had not been doing his catheter care but they are getting better at it now. When asked to explain, Resident #15 stated, "A few months ago, the staff was not doing the catheter care. Now they perform the dressing before I get out of the bed. The night nurse comes in before she leaves for the day and does the dressing around the tube." When asked if the staff clean the tube, the resident stated, "The CNAs are getting better about doing that too."

Review of Resident # 15's physician orders for the month of June 2013, documented, "Cath (catheter) care every shift; everyday; 0700 (7:00 a.m.) - 1500 (3:00 p.m.); 2300 (11:00 p.m.) - 0700." This order was dated 1/14/13.

Review of Resident # 15's TAR (treatment administration record) for June 2013 revealed no nurses signature for the day shift on 6/2/13 and 6/15/13. The TAR documented, "Cath Care every shift; Day; Night."

Review of Resident # 15's TAR for May 2013 revealed no nurse's signature on the day shift on: 5/1/13, 5/4/13, 5/10/13, 5/14/13, 5/15/13, 5/19/13 and 5/24/13. No documentation was on the TAR for the night shift for 5/10/13. The TAR documented, "Cath Care every shift; Day; Night."

Review of Resident # 15's TAR for April 2013 revealed no nurse's signature on the day shift on: 4/1/13, 4/2/13, 4/3/13, 4/6/13, 4/10/13 and 4/12/13 and on the evening shift on 4/8/13. The TAR documented, "Cath care every shift at 0900

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(9:00 a.m.) and 2100 (9:00 p.m.)."

The TAR for March 2013 revealed no nurse's signature on the day shift on: 3/2/13, 3/14/13, 3/15/13, 3/20/13, 3/21/13, and 3/25/13 and on the evening shift on 3/3/13 and 3/4/13. The TAR documented, "Cath care every shift at 0900 (9:00 a.m.) and 2100 (9:00 p.m.)."

Resident # 15's TAR for February 2013 revealed no nurse's signature on the day shift on 2/18/13 and 2/21/13 and on the evening shift on: 2/4/13, 2/8/13, 2/12/13, 2/13/13, 2/17/13, 2/18/13, 2/19/13 and 2/25/13. The TAR documented, "Cath care every shift at 0900 (9:00 a.m.) and 2100 (9:00 p.m.)."

The review of the TAR for January 2013 revealed no nurse's signature on the day evening shift on 1/29/13, 1/30/13, and 1/31/13. The TAR documented, "Cath care every shift at 0900 (9:00 a.m.) and 2100 (9:00 p.m.)."

An interview was conducted with LPN (licensed practical nurse) #13 on 6/20/13 at 2:58 p.m. When asked how often catheter care is provided, LPN #13 stated, "It's done every shift. We work 12 hour shifts." When asked what catheter care entails, LPN #13 stated, "It would be to clean around the insertion site of the catheter tube with soap and water and wipe from insertion site to the end of the tube, moving away from the insertion site." When asked who completes catheter care, LPN #13 stated, "The CNA's (certified nursing assistant) do it, but the nurse can do it."

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An interview was conducted with LPN #1, the unit manager on 6/20/13 at 3:04 p.m. When asked what catheter care is, LPN #1 stated, "The CNA cleans the tubing of the catheter when doing ADL (activities of daily living) with soap and water." When asked who performs catheter care on the residents, LPN #1 stated, "The CNAs do catheter care during ADL care. The nurses can do it. But the nurses have to ensure that it's done and done properly."

An interview was conducted with CNA #11 on 6/20/13 at 3:11 p.m. When asked if Resident #15 had had catheter care that morning, CNA #11 stated, "Yes, I did it during his ADL care." When asked what she performed, CNA #11 stated, "I clean the tubing with soap and water and moved from the skin out." When asked where she documented that the catheter care was given, CNA #11 stated. "I don't document it." When asked who does document it, CNA #11 stated, "I guess the nurse does."

An interview was conducted with LPN #3 on 6/20/13 at 3:13 p.m. When asked to show this surveyor where the catheter care was documented, LPN #3 showed this surveyor the TAR. When asked how she knows that it was done, LPN #3 stated, "I asked the CNA and she told me yes, it was done."

The administrative team was made aware of the above concern on 6/20/13 at 6:35 p.m.

An interview was conducted with the director of nursing, administrative staff member (ASM) #2 on 6/21/13 at 8:12 a.m. When asked who performs catheter care, ASM #2 stated, "The CNAs do it

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but the nurse can do it also." When asked who documents it and where is it documented, ASM #2 stated, "The nurse signs it off after communicating with the CNA." When asked if a blank is discovered on the TAR, what does that indicate, ASM #2 stated, "If it's not documented it's not done."

The review of the comprehensive care plan dated, 12/11/12 with a revision date of 3/22/13, documented, "Focus: (Resident #15) has an indwelling Suprapubic catheter; Terminal condition, HX (history) UTI (urinary tract infection)." The "Interventions" documented, "Change catheter per MD (physician) order and facility protocol. Check tubing for kinks each shift. Monitor for s/sx (signs and symptoms) of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature) urinary frequency, foul smelling urine fever, chills, altered mental status, change in behavior, change in eating patterns. US (urine) c/s (culture and sensitivity) per MD orders."

The facility policy, "Catheter Care" documented, "Policy: 1. Catheter care is to be provided by the CNA at least twice daily, as well as after each incontinent bowel movement.....Procedure:...G. Using soap and water clean the catheter tubing from the point of entry out for at least four inches using rotating outward movement. Do not pull on catheter...K. Report unusual observations to the charge nurse and document care in the (name of corporation) software program as indicated."

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No further information was obtained prior to exit.

F 323 SS=G 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide supervision and safety devices to prevent accidents for three of 28 residents in the survey sample, Residents #5, #13 and #3.

1. CNA (certified nursing assistant) #1 failed to provide supervision during a transfer from the wheelchair to the toilet. Resident #5 fell and sustained a hip fracture requiring hospitalization and surgery.

2. The facility staff failed to apply Resident #13's alarm (the alarm included a string and clip attached by a magnet to an alarm box. If the resident attempted to exit the bed or chair the string and clip section would separate from the alarm section setting off an alarm to alert the staff).

F 323

F 323

On June 25, 2013; a significant change assessment was completed to reflect Resident #5's recent improvement in her ADLs since obtaining a fracture. Resident #5 has recently improved from extensive assistance to limited assistance with her transfers and her care plan has been updated to reflect this need.

Resident #13 has not had an actual fall since February of 2012. Her alarm was reevaluated on June 24, 2013 and discontinued.

Resident #3's physician order for geri sleeves was clarified to wear as tolerated.

Any resident with devices that would assist in accident prevention have the potential to be affected. An audit of all residents who are at risk for falls will be completed. Accident prevention interventions will be reviewed for all residents and care plans will be updated accordingly. Any area identified as non-compliant will be corrected immediately.

Nursing staff will be educated on resident transfers and providing assistance as needed. Nursing staff will also be educated on the placement of preventative devices as ordered.

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3. The facility staff failed to apply the physician ordered arm protectors to prevent skin tears for Resident #3.

The findings include:

1 Resident #5 was admitted to the facility on 11/12/10 with a readmission of 12/24/12. Diagnoses included but were not limited to: anemia, thyroid disorder, osteoporosis, hip fracture, dementia, difficulty walking, muscle weakness, and macular degeneration.

The most recent comprehensive MDS (minimum data set) assessment, prior to Resident #5's fall with injury, was an annual assessment, with an ARD (assessment reference date) of 10/6/12. Resident # 5 was coded as being cognitively impaired for making daily decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living and was coded as requiring extensive assistance of one staff member for transfers. Resident # 5 was coded as being occasionally incontinent bowel and bladder. In Section G0300 "Balance During Transitions and Walking" of the MDS, Resident #5 was coded as "Not steady, only able to stabilize with staff assistance" for "Moving on and off toilet."

Review of Resident #5's MDS (minimum data set) assessment, a "Discharge assessment-return anticipated," with an ARD (assessment reference date) of 12/20/12, coded the resident as requiring limited assistance for transfers. Resident # 5 was coded as being occasionally incontinent of bladder and always continent of bowel.

Random observations of resident transfers will be conducted by the Director of Nursing or designee(s). Any staff member identified as not providing appropriate assistance will be provided one on one education. An audit of the placement of accident prevention devices will be conducted daily (five times a week for four weeks) by the Director of Nursing or designee(s), then twice a week (for a period of four weeks). Results of the audits will be submitted to the facility Quality Assurance committee to be analyzed and discussed for further recommendations.

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Review of the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/25/13, coded the resident as being cognitively impaired for making daily decisions. The resident was coded as requiring limited to extensive assistance of one staff member for all of her activities of daily living and requiring extensive assistance of one staff member for transfers. Resident # 5 was coded as being frequently incontinent bowel and bladder. In Section G0300 "Balance During Transitions and Walking" of the MDS, Resident #5 was coded as "Not steady, only able to stabilize with staff assistance" for "Moving on and off toilet."

Review of Resident #5's care plan dated 10/12/2012 documented, "Focus: (Resident #5) requires extensive staff assistance with ADL's r/t (related to) Dementia diagnosis." Under the heading "Interventions" documented, "Supervision with transfers."

Further review of Resident #5's clinical record documented:
"Fall Risk Assessment" dated 4/10/12 with a score of 14.0. It documented Resident #5 as "Moderate risk" for falls.
"Fall Risk Assessment" dated 12/26/12 with a score of 17.0. It documented Resident #5 as "High risk" for falls.
No other "Fall Risk Assessments" were located in the clinical record for Resident #5 (Note: according to the facility policy documented below this should have been completed quarterly).

Review of Resident #5's clinical record documented a "Fall Incident" dated 8/2/12.

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Under the heading "Description" it documented, "Writer heard resident screaming, write [sic] and CNA (certified nursing assistant) went into the room and noted resident on the floor. Observed in corner of the room near wheelchair and trash can at 6:30 p.m. Alert with confusion at the time. Noted with tremors on her hands. Noted with hematoma behind head approximately 6.0 cm (centimeters). No bleeding or injury. No bruises noted. Resident stated, 'I got up and fell.' She c/o (complained of) slight pain to her head on scale of 5/10 (five out of 10). Immediate action taken: Neurological assessment initiated, responded, MD notified immediately. New orders received to send out to ER (emergency room) for evaluation. Injury type: No injuries observed post incident."

Review of Resident #5's clinical record revealed a "Incident Note" dated 12/20/12. The note documented, "Type/Nature of Incident: Fall. 12/20/2012 Resident had a fall at 7:15 a.m., skin tear to right thumb; dressing applied; call put in to MD (medical doctor); awaiting for call back; unable to reach RP (responsible party); phone not answered." It further documented, "12/21/2012 no time, Resident toilets self with only supervision and requires no set up help."

Review of the "(Name of Hospital) History and Physical" dated 12/20/12 documented, "History of Present Illness: ...according to the records, ...she fell today and started complaining. This happened around 7 o'clock in the morning, when she fell. An x-ray was done, and she was found to have a left femur neck fracture, and she was sent to the hospital for further evaluation ..." Further review of the "(Name of Hospital) History and Physical" dated 12/20/12 documented,

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"EXAM: CAT (computed tomography) LOWER EXTREM (extremity) w/o (without) contrast - LEFT. Impression: Nondisplaced minimally impacted left femoral neck fracture confirmed. Plan: We will admit her to the fracture care order set. Her case was discussed with orthopedic surgeon (Name of Surgeon). The plan is for the OR (operating room) in the morning. We will keep her n.p.o (nothing by mouth) after midnight ... "

Review of the facility's fall investigation for Resident #5's fall on 12/20/12 revealed a facility "Associate Counseling Form" dated 12/20/12 that documented the following:

- "Name: (CNA #1)"
- "Department: Nursing"
- "Detailed Description of Incident: Failed to assist pt (patient) to bathroom resulting in resident fall."
- "Action Taken: education provided on alarms and fall risk pt. Make sure all pt have supervision with transfer to commode."
- "Associate comments: When I entered Resident's room (Name of Nurse) was assisting resident to w/c (wheelchair) and stated that resident needed to use the bathroom. I replied resident always uses bathroom herself, that's when I assisted resident to bathroom until she locked the wheels & (and) I left."

An interview was conducted on 6/20/13 at approximately 10:40 a.m. with CNA #1. When asked if the statement written next to "Associate comments" on the "Associate Counseling Form" dated 12/20/12 were hers, CNA #1 stated, "Yes." When asked about Resident #5's ability to

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transfer for toileting, she stated, "The resident always transferred herself from the wheelchair to the toilet independently, when she finished she would pull the call bell cord and I would assist resident from the toilet to the wheelchair." When asked what she meant by assistance, CNA #1 stated, "Assistance was cleaning the resident, providing and putting a brief on her, pulled her pants up while she held onto the grab bar next to the toilet, then resident would sit herself down in the wheelchair." When asked how she knew what the procedure was for transferring resident #5, CNA #1 stated, "I was told by another aid and observations of other staff working with her." CNA #1 stated she had been working on (Name of the Unit) since September 2012. She further stated, "I know the routine for (Resident #5), I always worked with her."

Review of Resident #5's ADL (activities of daily living) sheets dated December 2012 for transfers that were completed on all shifts documented:

· Four instances of Independence - No help or oversight.

· 30 instances of Supervision - Oversight, encouragement or cueing.

· 22 instances of Limited Assistance - Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance.

· Two instances of Extensive Assistance - Resident performed part of activity, weight bearing support.

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Two instances of Total dependence - Full staff performance.

An interview was conducted on 6/20/13 at approximately 4:55 p.m. with CNA #3. When asked what it meant to transfer a resident with supervision, CNA #3 stated, "Cueing."

An interview was conducted on 6/21/13 at approximately 9:30 a.m. with RN (registered nurse) #5, MDS Coordinator. When asked about the discrepancy in Resident #5's MDS dated 10/6/12 that coded the resident as requiring extensive assistance of one staff member for transfers and the care plan, reviewed six days later, dated 10/12/2012 that documented Resident # 5 required supervision with transfers, RN #5 stated, "It was an over site. Policy is to update the care plan as needed, it should have been updated." When asked what procedure is followed for updating care plans, she stated, "We follow the RAI manual."

An interview was conducted on 6/21/13 at approximately 10:50 a.m. with the Director of Nursing (DON) regarding Resident #5's fall on 12/20/12. When asked what type of support Resident #5 required for transfers, the DON stated, "She required supervision." When asked what was meant by supervision, she stated, "Oversight and you would be able to leave the room and check occasionally."

An interview was conducted on 6/21/13 at approximately 12:50 p.m. with OSM (other staff member) #5, Therapy Program Manager, regarding types of transfers. When asked what is

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meant by supervision during a resident transfer, OSM #5 stated, "Eyes only, no touching, verbal cueing."
An interview was conducted on 6/21/13 at approximately 1:00 p.m. with CNA #1. When asked who locked Resident #5's wheelchair after she took the resident into the bathroom, CNA #1 stated, "I did." When asked if she assisted resident #5 to the toilet, she stated, "No." When asked if she saw Resident #5 transfer herself to the toilet from the wheelchair, CNA #1 stated, "No, when I left the bathroom I saw (Resident #5) start to pull herself up using the grab bar on the wall." When asked if she saw Resident #5 stand up from the wheelchair, CNA #1 stated, "No."

On 6/20/13 at approximately 1:15 p.m., in an interview with the DON, she stated that fall assessments should be done on admission, quarterly, and as needed or after every fall.

An interview was conducted on 6/21/13 at approximately 2:30 p.m. in the presence of the administrator and DON regarding fall assessment for Resident #5 from July 2012 through October 2012. The administrator stated, "We're unable to locate any."

Review of the facility's policy "Falling Leaves Program" documented "1. A fall risk assessment will be completed by the admitting nurse on admission, quarterly and as needed, and will be addressed on the care plan."

In "Fundamentals of Nursing" 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 5. "Client safety is a priority in health care. You need to protect clients from physical

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and emotional injury by continually assessing for and eliminating safety hazards. Clients fall due to many factors, such as improper transfer techniques, client age, side effects of medications, impaired mobility, or confusion. Learn your agency's fall prevention program for reducing client falls. Programs that use a multidimensional approach in designing fall prevention strategies have the greatest reduction in fall rates."

The Administrator and DON were made aware of the concern for harm regarding Resident #5 on 6/20/12 at approximately 6:20 p.m.
No further information was provided prior to exit.

2. Clinical record review revealed, Resident #13 was a 90 year old female admitted to the facility on 4/15/11 with multiple diagnoses including syncope (light headedness) and collapse, osteoporosis, hyperlipidemia (abnormal fat/cholesterol levels in the blood), difficulty swallowing and depressive disorder.

Resident #13's quarterly Minimum Data Set (MDS) assessment dated 6/3/13 coded the resident as able to make herself understood and able to understand others. Her score on the Brief Interview for Mental Status was 3 out of 15, indicating she had severe cognitive impairment. She was totally dependent on staff assistance for all activities of daily living except eating and personal hygiene for which she needed extensive assistance. She had no falls since her last assessment.

Resident # 13's annual MDS assessment dated 3/7/13 was reviewed and documented she had no

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falls since her last assessment.

Her care plan dated 6/5/13 identified risk for falls due to unaware of safety needs, decreased functional mobility and inability to transfer independently as a focus. There were several interventions including bed and chair alarm.

Resident #13 was observed on 6/18/13 at 3:45 PM, and on 6/19/13 at 8:45 AM, 10:30 AM and 2:20 PM. She was observed in bed and in a chair. There was no alarm on her bed or chair.

A physician's order dated 6/14/13 documented the bed and chair alarm should be discontinued.

There were no nurse's notes explaining why the alarm was discontinued.

On 6/20/13 at 8:15 AM, the unit manager Licensed Practical Nurse (LPN) #1 stated the resident should have an alarm on her chair and bed. LPN #1 stated the alarm was discontinued from the physician's order sheet because it was a nursing intervention. She said the alarm was included as an intervention on the resident's care plan.

On 6/20/13 at 11:25 AM, Certified Nursing Assistant (CNA) #12 stated the resident did not use an alarm. She said the interventions which were in place for Resident #13 were on the care card taped to her closet door. An alarm was not listed on the card as an intervention. The care card was last updated on 1/4/12. CNA #12 stated it should be updated because her transfer needs had changed.

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On 6/20/13 the assistant director of nursing observed resident #13 and stated she did not have an alarm on her chair. She said the alarms were being discontinued from the physician's order sheet, but their use was documented in the care plan. She said she would check if the alarm intervention was documented in the resident's care plan.

On 6/20/13 at 1:10 PM, LPN #1 stated Resident #13 needed an alarm. She stated she saw that the resident did not have an alarm applied to her chair. LPN #1 stated the care cards were no longer used.

On 6/20/13 at 6:55 PM, this concern was shared with the administrator, the director of nursing, the assistant director and the assistant administrator.

3. Resident #3 was admitted to the facility on 2/23/12 with diagnoses that included but were not limited to: aphasia, muscle weakness, high blood pressure, stroke, depression, dysphagia, history of urinary tract infections, peripheral edema, urinary retention, osteoarthritis and hyperlipidemia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, dated 4/19/13 coded the resident as having both short and long term memory problems. The resident was coded as being severely impaired to make cognitive daily decisions. Resident #3 was coded as requiring extensive assistance of one to two staff members for bed mobility, dressing and eating. She was totally dependent on the staff for transfers from one surface to another, toileting

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needs, personal hygiene and bathing. The resident was incontinent of both bowel and bladder. In Section B - Hearing, Speech and Vision, Resident #3 was coded as being highly impaired to see in adequate light.

The resident was observed in her room on 6/19/13 at 8:40 a.m. Resident #3 was in her bed with pads on the side rails, both floor mats were down on either side of the bed. The resident had on a long sleeve shirt. There were no arm protectors visible. The resident was observed at 9:10 a.m. being fed by a staff member, there were no arm protectors visible. Resident #3 was again observed at 10:30 a.m. in bed with the head of the bed elevated, no arm protectors were visible. Incontinence care was observed at 11:10 a.m. Resident #3 had leg protectors on but no arm protectors on. Resident #3 was observed at 2:20 p.m. in bed, asleep on her back, her sleeves were observed halfway up her arm, no arm protectors were on.

On 6/20/13 at 8:38 a.m., Resident #3 was observed in bed, floor mats down, alarm on, with her call bell in reach. The resident had on a short sleeve shirt with no arm protectors on.

On 6/20/13 at 11:15 a.m. Resident #3 was observed in her chair by the nurse's station with her arm protectors on.

The physician orders, signed by the physician on 6/11/13, documented, "Geri sleeves (arm protectors) to bilateral arms, remove for bathing, every shift, every day."

The comprehensive care plan dated, 2/21/12 and

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revised on 2/19/13, documented, "(Resident #3) is a skin tear on her Rt (right) outer ankle and Lt (left) elbow with potential for impairment to skin integrity r/t (related to) decreased mobility, poor safety awareness, fragile skin, fungal rash to Rt breast, rash under both breast." The "Interventions" documented, "Skin observations."

Review of the Resident "Kardex" in the computer, documented, "Dressing: geri sleeves to arms and geri legs to BLE (bilateral lower extremities); remove for bathing."

An interview was conducted with CNA (certified nursing assistant) #8 on 6/20/13 at 8:56 a.m. When asked how a CNA finds out how to care for a resident, CNA #8 stated, "The nurse or the therapy department let us know what to do. Therapy will give us an in-service on any equipment that the resident might need or special transfer techniques for that resident." When asked if she gets pulled to another unit, how does she find out how to care for residents, CNA #8 stated, "The CNAs or nurses tell us what they need." CNA #8 returned five minutes later and stated, "There's a sheet of paper inside the closet door and it's on the kiosk."

An interview was conducted with CNA #9 on 6/20/13 at 9:05 a.m. When asked how she finds out how to take care of a resident, CNA #9 stated, "I believe it's in the care card book." When asked about inside the closet, CNA #9 stated, "No, we don't do that anymore." CNA #9 could not locate a care card book on the unit.

An interview was conducted with LPN (licensed practical nurse) #2 on 6/20/13 at 9:08 a.m. When

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asked if the facility uses a care card system that informs the staff how to care for a resident, LPN #2 stated, "I've not seen anything here for that."

An interview was conducted with CNA #2 on 6/20/13 at 9:10 a.m. When asked how she finds out how to take care of a resident, CNA #2 stated, "On the sheet of paper in the back of the closet door."

An interview was conducted with CNA #9 on 6/20/13 at 9:14 a.m. When asked how a staff member finds out how to take care of a resident, CNA #9 stated, "On the kiosk (computer screen on wall) and we get report from the other CNAs."

An interview was conducted with the unit manager, LPN # 8 on 6/20/13 at 9:18 a.m. When asked how the CNAs learn how to care for a resident, LPN #8 stated, "It's in (name of computer program) in the Point of Care section. The Kardex directly linked to the care plan." When asked if there are any other ways the staff determine how to care for a resident, LPN #8 stated, "They get report from the nurses and other CNAs."

The administrative team was made aware of these findings at the end of the day meeting on 6/20/13 at 6:35 p.m. A copy of the facility policy for following physician orders was requested.

An interview was conducted with the director of nursing, administrative staff member (ASM) #2, on 6/21/13 at 8:12 a.m. When asked how the staff knows how to care for a resident, ASM #2 stated, "They are verbally told by the nurses and other CNAs. It's in the care plan." When asked if

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F 323	Continued From page 47 the CNAs have access to the care plan, ASM #2 stated, "No." ASM #2 stated, "They are instructed during report." When asked if the CNAs receive report every day, ASM #2 stated, "Only if there is a change in condition." When asked where it is documented for the staff to know how to care for a resident, ASM #2 stated, "I will get back with you." On 6/21/13 at 9:55 a.m. registered nurse (RN) #7, the assistant director of nursing, informed this surveyor that the "CNAs have access to the Kardex through point of care." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	F 334 **Resident #5's responsible party has been contacted regarding the administration of the flu and pneumococcal vaccine and has not responded to the facility's attempts. The pneumococcal vaccine will be administered upon receiving the consent. The flu vaccine will be administered prior to flu season as recommended by the CDC guidelines if consent is received.** F 334 Continued on Next Page	

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F 334	Continued From page 48	F 334	F 334 - Continued	

immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

An audit of all current residents' immunizations was completed on July 9, 2013. Any residents who are identified as not having been offered an immunization will be provided education and consent forms for the appropriate immunizations to be administered as recommended by the CDC guidelines.

Facility Infection Control Nurse has reviewed the policy and procedure for immunization administration. All new residents will be educated and offered immunizations and consent will be obtained during the admission process. Immunizations will be administered per physician's orders upon admission.

An admissions checklist (including immunization consents) will be completed for each new admission. Current and new admission immunizations are recorded by the facility Infection Control Nurse in the immunization log.

A monthly audit of all facility immunizations will be completed by the facility Infection Control Nurse and the results of the audit will be discussed for further recommendations during the facility Quality Assurance meetings.

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(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility policy review and clinical record review, the facility staff failed to ensure one of 28 sampled residents, (Resident # 5), was offered an influenza and pneumococcal vaccine.

The findings include:

Resident #5 was admitted to the facility on 11/12/10 with a readmission of 12/24/12. Diagnoses included but were not limited to: anemia, thyroid disorder, osteoporosis, hip fracture, dementia, difficulty walking, muscle weakness, and macular degeneration.

Review of the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/25/13, coded the resident as being cognitively impaired for making daily decisions. The resident was coded as requiring limited to extensive assistance of one staff member for all of her activities of daily living. Resident # 5 was coded as being frequently incontinent bowel and bladder.

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In Section O, Resident #5 was coded as not having received the influenza and pneumococcal vaccine while in this facility. Section O documented that it was "Not offered" to Resident #5.

Review of the clinical record revealed an immunization record that did not document an influenza or pneumococcal vaccine had been administered.

An interview was conducted on 6/21/13 at approximately 8:00 a.m. with the Director of Nursing (DON) regarding Resident #5's influenza and pneumococcal vaccine. The DON stated they had failed to obtain the consent for the influenza and pneumococcal vaccine and failed to offer it.

The facility policy "Policy for Influenza Vaccination of Residents" documented, "It is the policy of this facility that annually, in the fall, residents will be offered immunization against influenza. The time for influenza will follow the recommendations of the Centers for Disease Control (CDC) and the state department of health." Under the heading "Procedures for Influenza Vaccination of Residents" it documented,

- "Obtain written informed consent from resident; this should be included on admission.
- Give vaccine as per facility administration policy.
- Document vaccination in the medication Administration record and in Nurses Notes."

The facility policy "Pneumococcal Vaccination of Residents" documented, "Procedure: 1. Each resident/patient and/or their agent (responsible

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F 334	Continued From page 51 party) will be asked upon admission if they have received the pneumococcal vaccination prior to admission during the admission process with this information being recorded in the Admission Agreement. 3. Obtain written informed consent from each resident/patient ... (a) Documentation of vaccination is recorded on the MAR for all residents/patients." Annual influenza vaccines are recommended for older clients and clients with chronic illnesses. This includes clients older than 65 years of age; clients of any age with chronic disease of the heart, lung or kidneys; clients with diabetes; and clients with immunosuppression or severe forms of anemia. The vaccine is also recommended for people in close or frequent contact with anyone in the high-risk groups ...The vaccine is most effective in reducing the severity of illness and the risk of serious complications and death. Fundamentals of Nursing; Perry and Potter 6th edition, page 1095. Pneumococcal vaccine is recommended for clients at increased risk of developing pneumonia, those with chronic illnesses or immunosuppression (such as HIV/AIDS), those living in special environments such as nursing homes or the American Indian population, and clients over the age of 65. Perry and Potter's Fundamentals of Nursing 6th edition, page 1096 The Administrator and Director of Nursing were made aware of this finding on 6/21/13 at approximately 8:30 a.m. No further information was provided prior to exit.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility document review and staff interview it was determined that for 2 of the 28 sampled residents (Residents #10 and #11) the facility staff failed to ensure the pharmacist's recommendations were acted upon by the physician and a drug regimen review was completed by the pharmacist.

1. The facility staff failed to ensure the pharmacist's recommendations were acted upon by Resident #10's physician.

2. The facility staff failed to ensure a monthly drug regimen review was completed for May 2013 for Resident #11.

The findings include:

1. Clinical record review revealed, Resident #10

Resident #10's pharmacist recommendations were reviewed with the physician and acted upon on July 11, 2013.

Resident #11's attending physician was notified regarding the failure of a drug regimen review for May, 2013. A drug regimen review was completed by the facility consultant pharmacist in June, 2013.

An audit of all pharmacist recommendations for the last thirty (30) days will be completed. Any recommendations identified as not having been reviewed by or acted upon by the facility nursing staff and physician will be addressed immediately.

The consultant pharmacist will review each resident's current drug regimen on a monthly basis and provide a report to the Director of Nursing and/or designee(s). Each recommendation will be reviewed with the physician by each Unit Manager and documented in the clinical record. All recommendations will be submitted to the Director of Nursing for validation. Any area of non-compliance will be corrected immediately and reviewed with the facility Medical Director.

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was a 77 year old male admitted to the facility on 3/20/09 with multiple diagnoses including major depression, senile dementia, difficulty speaking, high blood pressure, chronic pain, and atrial fibrillation (irregular heartbeat). His quarterly Minimum Data Set assessment dated 5/13/13 coded the resident as sometimes able to make himself understood and sometimes able to understand others. His score on the Brief Interview for Mental Status was 3 out of 15, indicating he had severe cognitive impairment. He was totally dependent on staff assistance for all activities of daily living.

The pharmacy progress note dated 12/13/12 at 10:48 documented the pharmacist recommended that the resident's physician review the use of Wellbutrin (anti-depressant *).

The pharmacy progress note dated 1/18/13 at 13:44 documented the physician evaluation of the Wellbutrin therapy was pending.

The pharmacy progress note dated 2/18/13 at 12:09 documented "Pending MD".

The pharmacy progress note dated 3/20/13 at 12:46 documented the pharmacist recommended that the resident's physician review the use of anti-depressant therapy.

Review of the clinical record revealed there was no evidence of the pharmacist's recommendation or the physician's response.

On 6/19/13 at 2:15 PM, the director of nursing (DON) was asked to provide the recommendations for Resident # 10, and

F 428 - Continued

A monthly audit/review of previous recommendations will be conducted by the consultant pharmacist. Results of the audits will be submitted to the facility Quality Assurance committee for further discussion and recommendations.

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evidence the physician acted on them.

On 6/21/13 at 9:55 AM, Registered Nurse (RN) #1 provided the recommendations. She stated the recommendations were not signed by the physician.

On 6/21/13 at 9:30 AM, the pharmacist Other Staff Member (OSM) #2 stated she wrote the recommendations when she worked for the previous pharmacy provider. OSM #2 stated she struggled toward the beginning of the year getting the recommendations "back" from the physicians. She said if she did not receive a response on her first visit to the facility after making a recommendation she wrote pending on the review. She said if the physician did not respond in 60 days she would repeat the recommendation.

On 6/21/13 at 12:30 this concern was shared with the administrator, the director of nursing and the regional director. The director of nursing stated the facility staff had not found the physician's response.

* This information was obtained from the Geriatric Dosage Handbook 12th Edition pages 191 and 1580.

2. Resident #11 was originally admitted to the facility on 6/27/12 and readmitted on 9/20/12 with diagnoses including, but not limited to, anemia, atrial fibrillation, hypertension, viral hepatitis type B, diabetes mellitus, non-Alzheimer's dementia, depression, dehydration, esophageal reflux and dysphagia. On the most recent MDS (minimum data set), an annual assessment with an ARD

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(assessment reference date) of 5/23/13, the resident was coded as having scored a 15 out of 15 on the Brief Interview for Mental Status. This score indicates the resident has no cognitive impairment for making daily decisions. The resident was coded as needing supervision assistance with set-up for bed mobility, transfers, eating, ambulation and locomotion on the unit. The resident was coded as needing limited assistance of one staff member for dressing, toileting and hygiene. Resident #11 was coded as needing extensive assistance of one staff member for bathing.

A review of the clinical record for Resident #11 revealed no evidence of a medication regimen review by the consultant pharmacist for May 2013.

An interview was conducted on 6/20/13 at 2:00 p.m. with OSM (other staff member) #6, the consultant pharmacist of record for Resident #11 during May 2013. OSM #6 was asked about the process followed for monthly medication regimen review. OSM #6 stated, "I would come in and get a list of residents. Sometimes I got the list from the receptionist. Sometimes I got the list from each unit. I came in and got the list of the current residents. And then I just went down the list and did the review." When asked if OSM #6 performed a medication regimen review on every current resident every month, OSM #6 stated, "Well yes. That was the point wasn't it." When asked if OSM #6 specifically remembered performing a medication regimen review for Resident #6 for May, 2013, OSM #6 stated, "I'm sure I did it. I did all of them. And I left the papers with the DON (director of nursing.) There

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must be some kind of error for May. If it is not in PCC (Point/Click/Care - the facility's electronic clinical record), then that was a mental error."

ASM (administrative staff member) #1, the facility administrator, and ASM #2, the director of nursing, were informed of this finding and of the results of the interview with OSM #6 in a meeting on 6/20/13 at 2:10 p.m. ASM #2 stated, "He did not leave those papers for me. None of them." ASM #1 stated, "It may be that we just don't have it [evidence of the medication regimen review.]"

A facility policy on medication regimen reviews was requested from ASM #1 and ASM #2 in a meeting on 6/20/13 at 6:25 p.m.

A review of the facility policy entitled "Consultant Pharmacist Services" revealed the following:
"Policy: The consultant pharmacist. .is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, that are consistent with current standards of practice, and that meet state and federal requirements."
"Procedure: 1. Conduct a medication regimen review for Facility residents at least monthly."

No further information was provided prior to exit.

F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug

F 431

All insulin vials observed by the surveyor as not dated were discarded immediately.

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F 431	Continued From page 57 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure proper labeling and storage of insulin on four of six medication carts. The facility staff failed to date multi-dose insulin vials when they were opened.	F 431	F 431 - Continued **Any resident receiving insulin has the potential to be affected. New multi dose insulin vials were opened and dated for the use of insulin administration.** **Licensed nurses will be educated on the proper labeling and storage of multi dose insulin.** **Each medication cart will be checked daily (five times a week for a period of four weeks) and twice a week (for a period of four weeks) by the Director of Nursing or designee(s) to assure all multi dose insulin vials are labeled, dated and within the expiration dates. Any area of non-compliance will be corrected with one on one education provided to the licensed nurses as needed.** **Results of audits will be reviewed for further discussion and recommendations during the facility Quality Assurance meetings.** Completion Date: July 30, 2013	

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The findings include:

During an observation of the Victory Court/Commonwealth (300/400) Unit. medication cart #2 was observed to have two multi use vials of Lantus insulin and one of Novolin R insulin open and in use with no documented open date on either vials or boxes that the vials were stored in. Observation of Medication cart #3 on the same unit revealed two multi dose vials of Lantus insulin also open and in use with no open date documented on either the vials or boxes that the vials were stored in.

Interview on 6/21/13 at 10:10 a.m. with LPN (licensed practical nurse) #8, the unit manager, revealed that the vials, "Should have dates when they are opened, they (nurses) are supposed to date them when they open them."

Observation of the Old Dominion/Centennial Unit (A/B Unit), (100/200 hall) revealed that the 100 hall medication cart contained one multi dose vial of Novolin R* insulin and one multi dose vial of Lantus** insulin that were open and in use with no documented open date on either vials or boxes that the vials were stored in.

Interview with LPN #14 revealed, "We normally put a date on the box when we open the insulin."

Further observation of the Old Dominion/Centennial Unit (A/B Unit), (100/200 hall) revealed that the 200 hall medication cart contained one multi dose vial of Humalog*** insulin that was open with no documented open date on the vial or box that the vial was stored in.

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During an interview on 6/21/13 at 10:20 a.m. with LPN #1, the unit manager, stated, "I will take them off the cart."

During an interview on 6/21/13 at 10:35 a.m. with ASM (Administrative staff member) #3, the assistant administrator, and ASM #6, regional corporate staff member, these observations were revealed. At this time a request for facility policies and the drug information (that staff members have access to) on each medication was requested.

An interview on 6/21/13 at 10:50 a.m. with ASM #2, the director of nurses, this concern was discussed.

The facility policy provided by ASM #6 was reviewed, "Pharmacy Policy and Procedure Manual" documented: under "Procedure #5. Follow the manufacturer's instruction for storage. Ensure that the opened date is documented on the vial or pen. #6. Check the expiration date prior to administration to ensure it is within the usage date. Expired insulin should be immediately discarded. Vials and pens without an open date recorded should be discarded."

Manufacturer's information provided by ASM #6 documented: "Humalog vials, cartridges, pens and Humalog KwikPen should be stored at room temperature, below 86 degrees F and must be used within 28 days or be discarded, even if they still contain Humalog."

*Novolin R & ***Humalog-"rapid-acting insulin used in the treatment of moderated to severe

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CARRIAGE HILL HEALTH AND REHAB CENTER	6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407

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diabetic ketoacidosis or hyperosmolar hyperglycemia." Taken from the facilities' resource drug book, "Nursing 2010 Drug Handbook" by Wolters Kluwer/Lippincott, Williams & Willikins1056.

** Lantus - "Treatment of adult and pediatric (6 years and older) with type 1 diabetes mellitus or adults with type 2 diabetes mellitus who require long-acting insulin to control hyperglycemia." "Discard opened vials or cartridge system after 28 days whether refrigerated or not." Taken from the facilities' "Nursing 2010 Drug Handbook" by Wolters Kluwer/Lippincott, Williams & Willikins 1052.

According to Fundamentals of Nursing 6th edition, Perry and Potter, page 878, "For multi-dose vial, make label that includes date of mixing, concentration of medication per milliliter and nurse's initials."

F 465 483.70(h)
SS=D SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, the facility staff failed to ensure five of 80 resident rooms were maintained in homelike environment.

F 431

F 465

F 465 **The walls in rooms 305 and 401 were repaired by patching, sanding and painting the scratched and nicked areas. The drawer front of the closet of room 208 was replaced/repaired.**

The adhesive covering on the night stand in room 103 will be removed and a varnish will be applied to surface. The adhesive covering to the night stands and wardrobes of room 307 will be removed and a varnish will be applied to the surface.

F 465 Continued on Next Page

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F 465	Continued From page 61 Five resident rooms were observed with damaged walls and furniture that was in need of repair. The findings include: Observation was made of the following rooms on 6/19/13 at 8:30 a.m. with the following findings: Room 305 had deep scratches on the wall with the window, next to the bed. Room 401 had nicks in the wall behind the bed. Room 208 the drawer front was missing on the closet of the door bed. The nightstand cabinet door was missing on the window side of the room. On 6/20/13 at 8:25 a.m. room 103 was observed. The adhesive covering on the night stand and wardrobe were peeling off. On 6/20/13 at 1:30 p.m. room 307 was observed. The adhesive covering was peeling off the night stand and wardrobe of both sides of the room. There was no adhesive covering on the top drawer and doors of the wardrobe on the window bed. The above rooms were shown to other staff member (OSM) #1, the maintenance director, on 6/21/13 at 9:00 a.m. He was unaware of the missing drawer and cabinet door in room 208. He stated that the peeling adhesive covering is a continuing project. The wardrobes are old and	F 465	F 465 - Continued **A walkthrough and inspection of each resident room will be conducted by the Administrator and Maintenance Director to identify any other areas that would require immediate repair. Work orders will be initiated for completion by the Maintenance department and each identified area will be repaired accordingly.** **Staff will be educated on the recognition of repair requirements and the facility work order process. A weekly review of work orders will be conducted by the facility Administrator or designee for validation of completed repairs. Random walkthroughs and room rounds will be conducted on an ongoing basis to identify areas in need of repair.** **Results of the walkthroughs and room rounds will be shared in the monthly Quality Assurance meetings for further discussion and recommendations.** Completion Date: July 30, 2013	

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taking all of the covering off has been the solution until new wardrobes can be ordered.

When asked how the staff informs the maintenance department of any broken equipment, OSM #1 stated, "They fill in a work order and put it on the door of the maintenance office. Or they can document the work order in the "Maintenance Book" on each floor." There were no work orders filed for the concerns identified above.

An interview was conducted with RN (registered nurse) #1 on 6/21/13 at 10:15 a.m. When asked how the staff communicates with the maintenance department when something is broken, RN #1 stated, "We fill in a work order. If they are in the building, I page them."

An interview was conducted with CNA #7 on 6/21/13 at 10:22 a.m. When asked how she would inform the maintenance department of a piece of equipment that is broken or need of repair, CNA #7 stated, "They have slips of paper on their door. I go there and fill it in and leave it in the box."

The facility policy, "Work Orders" documented, "Procedure: 1. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the maintenance supervisor. 2. If shall be the responsibility of the department directors to fill out and forward such work orders to the maintenance supervisor. 3. A supply of work orders is maintained at each nurse's station. 4. Work order requests should be placed in the appropriate file basked at the nurses' station. Work orders are picked up daily. 5. Emergency

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F 465	Continued From page 63 requests will be given priority in making necessary repairs. Emergencies are defined as problems that interfere with water temperatures, heating, cooling, water supply, significant leaks, call bell system, fire alarm system, etc." The administrator was made aware of the above concerns on 6/21/13 at 10:00 a.m.	F 465		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to obtain physician ordered laboratory testing for one of 28 residents in the survey sample; Resident #2. For Resident #2, the facility staff failed to obtain physician-ordered labs for Valproic Acid levels and Ammonia levels. The findings include: Resident #2 was most recently admitted to the facility on 12/2/12 with the diagnosis of but not limited to Parkinson's, psychosis, bipolar, diabetes, chronic kidney disease, high blood pressure, and acute renal failure. The most recent MDS (Minimum Data Set) assessment	F 502	F 502 **Resident #2's labs were drawn on June 26, 2013.** **An audit of all physician ordered lab work for the last thirty (30) days will be conducted. Any lab orders identified as not having been drawn will be addressed.** **Licensed nurses will be educated on obtaining lab work as well as the facility protocol for lab tracking.** **Lab tracking logs will be reviewed daily (five times a week for a period of four weeks) and then twice a week (for a period of four weeks) by the Unit Manager or designee. Any lab identified as having not been drawn will be addressed.** **Results of daily and weekly lab audits will be reviewed for further discussion and recommendations during the facility Quality Assurance meetings.** Completion Date: July 30, 2013	

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was a quarterly assessment with an ARD (Assessment Reference Date) of 4/9/13. Resident #2 was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total assistance from staff for bathing; extensive assistance from staff for transfers, ambulation, dressing, eating, and hygiene; and was frequently incontinent of bowel and bladder.

A review of the clinical record revealed the most recent POS (Physician's Order Sheet), signed by the physician on 6/3/13, contained the following orders:

Valproic acid and Ammonia** levels every four to six weeks. This order was dated 2/26/13. This order was based on recommendation by the resident's psychiatrist. The resident visited the psychiatrist and obtained the recommendation on 2/26/13.

Further review of the clinical record revealed the Ammonia level was obtained on 2/27/13. There was no further evidence of any ammonia levels being obtained since 2/27/13 to the date of clinical record review during survey on 6/19/13.

Continued review of the clinical record failed to reveal evidence the Valproic Acid level was obtained every four to six weeks as recommended by the psychiatrist, and as most recently ordered by the physician on 2/26/13.

On 6/20/13 at 8:45 a.m., an interview was conducted with LPN #1 (Licensed Practical Nurse #1, the unit manager). Regarding the ammonia levels, she stated, "It wasn't done. It was totally

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missed." Regarding the Valproic Acid levels that were to be done every four to six weeks, she stated that the labs were obtained per the previous order of every three months and not the most recent order of every four to six weeks.

A review of the facility policy for "Laboratory Procedure" documented, "Procedure: A. Obtain a physician's order for all lab work and write the order on the physician's order sheet. B. Fill out the necessary lab slips. C. When the blood is drawn, the nurse drawing the blood documents in the Nurse's Notes when drawn, by whom, type of test and that specimen is sent to the lab. D. The facility will maintain a lab tracking log for laboratory tests ordered. When the results come back, check off in the book as it has been returned. The log is reviewed monthly and PRN by the DON and/or ADON. E. The results are checked by the charge nurse and the physician is notified of the results. F. All lab results are kept in a designated place until seen and signed by the physician. G. The lab results are filed in the patient's chart under the Laboratory section."

On 6/20/13 at the end of day meeting at 6:23 p.m., the Administrator, Assistant Administrator, Director of Nursing, and Corporate Nurse Consultant, were made aware of the findings.

According to Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), "The physician or health care provider is responsible for directing the medical treatment of a patient."

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**The following was obtained from http://www.nlm.nih.gov/medlineplus/
Therapeutic drug levels are laboratory tests to look for the presence and the amount of specific drugs in the blood....The Valproic acid: 50 to 100 mcg/mL (microgram/ milliliter). "
Website:
http://www.nlm.nih.gov/medlineplus/ency/article/003430.htm

The ammonia test measures the amount of ammonia in a blood sample....Drugs that can falsely raise the blood ammonia level include:

- Alcohol
- Acetazolomide
- Narcotics
- Valproic acid

A high-protein diet can also raise the blood ammonia level. Talk to your health care provider before this test if you are taking any of these medications....This test may be done if you have or your doctor thinks you have a condition that may cause a toxic buildup of ammonia. It is most commonly used to diagnose and monitor hepatic encephalopathy, a severe liver disease....Ammonia (NH3) is produced by cells throughout the body, especially the intestines, liver, and kidneys. Most of the ammonia produced in the body is used by the liver to produce urea. Urea is also a waste product, but it is much less toxic than ammonia....Ammonia is especially toxic to the brain. It can cause confusion, lethargy, and sometimes coma....The normal range is 15 - 45 micrograms per deciliter (mcg/dL)."
Website:
<http://www.nlm.nih.gov/medlineplus/ency/article/003506.htm>

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	F 514	

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility failed to maintain a complete and accurate clinical record for two of 28 residents in the survey sample, Resident #11 and Resident #5.

1. For Resident #11, the facility staff failed to accurately document the administration of treatments and medications on the medication administration and treatment administration records for January 2013, February 2013, March 2013, April 2013, May 2013 and June 2013.

2. For Resident #5, the facility staff failed to document on the MAR (medication administration record) that the medication Prolia* was administered as ordered by the physician.

F 514

Resident #11's attending physician was notified regarding the instances in which there wasn't accurate documentation in her medication administration records and treatment administration records.

Resident #5's attending physician was notified that the medication administered was not documented. No new orders were received at that time.

An audit of all medication administration records and treatment administration records for the last thirty (30) days will be completed. Any area of non-compliance will be addressed appropriately.

Licensed nurses will be educated on accurately documenting in each residents medication administration record and treatment administration record.

The Director of Nursing and/or designee(s) will audit all medication administration and treatment administration records daily (five times a week for a period of four weeks) and twice a week (for a period of four weeks). Any area identified as non-compliant will be addressed appropriately.

Results of these audits will be submitted for review, discussion and further recommendations to the facility Quality Assurance Committee.

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*Prolia - Denosumab injection (Prolia) is used to treat osteoporosis in women."

The findings include:

1. Resident #11 was originally admitted to the facility on 6/27/12 and readmitted on 9/20/12 with diagnoses including, but not limited to, anemia, atrial fibrillation, hypertension, viral hepatitis type B, diabetes mellitus, non-Alzheimer's dementia, depression, dehydration, esophageal reflux and dysphagia. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/23/13, the resident was coded as having scored a 15 out of 15 on the Brief Interview for Mental Status. This score indicates the resident has no cognitive impairment for making daily decisions. The resident was coded as needing supervision assistance with set-up for bed mobility, transfers, eating, ambulation and locomotion on the unit. The resident was coded as needing limited assistance of one staff member for dressing, toileting and hygiene. Resident #11 was coded as needing extensive assistance of one staff member for bathing.

A review of the physician order sheet for Resident #11 for January 2013, dated 12-26-12 and signed by the physician on 1/17/13, revealed the following orders:
*Azelastine 0.14% (a decongestant) - Nasal dose: 1 spray each nostril at HS (bedtime)
*Digoxin (an anti-arrhythmic for the heart) - oral (By mouth) Dose: 0.25 mg (milligrams) every day
*Ferrous Sulfate (a nutritional supplement) - oral (By Mouth) Dose: 325 (65 Fe [iron]) tablet oral (By mouth) every day

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*Lasix (Furosemide) (a diuretic) - oral (By mouth) Dose: 20 mg every day
*Lisinopril (an anti-high blood pressure) - oral (By mouth) Dose: 2.5 mg every day
*Oxybutynin Chloride (an anti-bladder spasmodic) - oral (By mouth) Dose: 5 mg every day
*Potassium Chloride (a nutritional supplement) - oral (By mouth) Dose: 10 mEq (milliequivalents) every day
*Senna (Sennosides-Docusate Sodium) (a laxative/stool softener) - oral (By mouth) 8.6-50 mg every day
*Vitamin B6 (Pyridoxine) (a nutritional supplement) - oral (By mouth) Dose: 50 mg every day
*Zoloft (Sertraline HCl) (an antidepressant) - oral (By mouth) Dose: 25 mg every day.
*Zoloft (Sertraline HCl) (an antidepressant) - oral (By mouth) Dose: 50 mg every day.
*Resource 2.0 (a nutritional supplement) - oral (By mouth) Dose: 60 cc (cubic centimeters) every day
*Calcium-Vitamin D (a nutritional supplement) - oral (By mouth) Dose: 600-400 mg every day
*Clonidine (an antihypertensive) - oral (By mouth) Dose 0.1 mg every day bid (twice a day)
*Coreg (Carvedilol) (an antihypertensive) - oral (By mouth) Dose: 150 mg every day bid
Pain rating of 0-10 q (every) shift
*TED hose (thromboembolism-deterrent) (anti-blood clot stockings) to be worn during the day only; off in HS
Cleanse after each incontinent episode, apply preventive *zinc barrier ointment (a moisture barrier cream) to buttocks q shift and prn (as needed).

A review of the physician order sheet for Resident

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#11 for April 2013, dated 3/26/13 and signed by the physician on 4/11/13, revealed the following orders:
Cleanse area to rt (right) cheek with wound cleanser, dry and apply triple antibiotic ointment until resolved 2X (two times) every day.

A review of the physician order sheet for Resident #11 for May 2013, dated 4/30/13 and signed by the physician on 5/3/13, revealed the following orders:
Cleanse wound under chin with wound cleanser, dry thoroughly and apply TAO (triple antibiotic ointment) every day until healed.

A review of the medication administration record for Resident #11 for January 2013 revealed the following
1/18/13: no documentation for the administration of Digoxin, Lasix, Lisinopril, Oxybutynin, Potassium Chloride, Senna, Vitamin B6, Zoloft, Resource 2.0, Calcium-Vitamin D, Clonidine and Coreg
1/23/13, 1/26/13, 1/28/13, 1/29/13, 1/30/13, and 1/31/13: no documentation for the administration of Azelastine.

A review of the medication administration and treatment administration records for Resident #11 for February 2013 revealed the following:
2/13/13: no documentation for pain rating for night shift
2/16/13: no documentation for TED hose for evening shift; no documentation for incontinence care for evening shift
2/18, and 2/21/13: no documentation for pain rating for night shift; no documentation for TED hose for the day shift; no documentation for

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incontinence care for the day shift
2/25/13: no documentation for pain rating for night shift; no documentation for TED hose for the day shift; no documentation for incontinence care for the day or evening shifts

A review of the medication administration and treatment administration records for Resident #11 for March 2013 revealed the following:
3/3/13: no documentation for cheek wound care for the evening shift
3/4/13: no documentation for pain rating for day shift; no documentation for TED hose for the day shift; no documentation of cheek wound care for day or evening shifts
3/5, 3/9, and 3/11/13: no documentation for pain rating for day shift
3/14, 3/15, 3/19, and 3/20/13: no documentation for TED hose for day shift; no documentation for cheek wound care for day shift; no documentation of incontinence care for day shift

A review of the medication administration and treatment administration records for Resident #11 for April 2013 revealed the following:
4/1/13: no documentation for cheek wound care for day shift
4/2, 4/3, 4/6, 4/10, and 4/12/13: no documentation for cheek wound care for day shift; no documentation for incontinence care for day shift
4/7, 4/11, 4/16, 4/20, 4/21/13 and 4/30/13: no documentation for incontinence care for day shift
4/8/13: no documentation for cheek wound care for evening shift

A review of the medication administration and treatment administration records for Resident #11

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for May 2013 revealed the following:
5/4, 5/10, and 5/14/13: no documentation for incontinence care for day shift
5/15/13: no documentation for incontinence care for day shift; no documentation of TED hose for day shift; no documentation of chin wound care for day shift
5/19 and 5/24/13 no documentation for incontinence care for day shift; no documentation of chin wound care for evening shift
5/27/13: no documentation of chin wound care for evening shift

A review of the medication administration and treatment administration records for Resident #11 for June 2013 revealed the following:
6/3/13: no documentation for chin wound care for day and evening shifts
6/15/13: no documentation for incontinence care for day shift

In an interview on 6/20/13 at 11:05 a.m., LPN (licensed practical nurse) #1 was asked about the process for documenting medications and treatments given and not given to residents. LPN #1 stated, "I document on the computerized MAR (medication administration record). If I don't give it, I document it on the MAR and the nurse notes." When asked what a blank in a MAR or TAR (treatment administration record) for a resident would signify, LPN #1 stated, "Well, I guess you couldn't tell whether the medicine was given or not."

In an interview on 6/20/13 at 11:30 a.m., LPN #2 was asked about the process for documenting medications and treatments given and not given

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	495396	A. BUILDING _____ B. WING _____	C 06/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HILL HEALTH AND REHAB CENTER	6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407

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to residents. LPN #2 stated, "I pull up the MAR on the computer. I click 'yes' to signify that I gave the med. If I don't give the med, I click 'no' and it gives me different options the whole shift."

ASM (administrative staff member) #1, the facility administrator, and ASM #2, the director of nursing, were informed of the blanks in the medication administration and treatment administration records for Resident #11 in a meeting on 6/19/13 at 3:25 p.m. ASM #2 was shown the documents with blanks. ASM #2 stated, "Well, I feel like these meds were given and the treatments were done. I need to look into this. There should not be blanks."

A facility policy on medication/treatment administration documentation was requested from ASM #1 and ASM #2 in a meeting on 6/20/13 at 6:25 p.m.

A review of the facility policy entitled "General Guidelines for Medication Administration" revealed the following procedure: "15. [After giving the medication], return to the medication cart and document medication administration with initials on the medication administration record (MAR) immediately after administering medication to each resident. 16. If a resident refuses medication, document on the MAR. Note refusal or ingestion of less than 100% of dose on the MAR in the designated area."

No further information was provided prior to exit.

*Information on medication uses was found on the National Institutes of Health website Medline Plus.

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http://www.nlm.nih.gov/medlineplus/medlineplus.html
2. Resident #5 was admitted to the facility on 11/12/10 with a readmission of 12/24/12. Diagnoses included but were not limited to: anemia, thyroid disorder, osteoporosis, hip fracture, dementia, difficulty walking, muscle weakness, and macular degeneration.

Review of the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/25/13, coded the resident as being cognitively impaired for making daily decisions. The resident was coded as requiring limited to extensive assistance of one staff member for all of her activities of daily living. Resident # 5 was coded as being frequently incontinent bowel and bladder.

Review of the "Physician's Order Sheet" dated April 2013 documented, "Prolia (Denosumab) 60 MG/ML (milligram/milliliter) solution Subcutaneous (beneath the layers of the skin). Every 182 days. Give prolia 60MG/ML, 1ml by injection every 6 months. Start date 4/17/13."

Review of the MAR (medication administration record) dated April 2013 documented, "Prolia (Denosumab) Dose: 60 MG/ML. Start date 4/17/13. Every 182 days. Give prolia 60MG/ML, 1ml by injection every 6 months." Further review of the April 2013 MAR did not document the administration of the medication prolia on 4/17/13 or any other date in the month of April.

Review of Resident #5's care plan dated 1/2/13 documented, "Focus: (Resident #5) has idiopathic osteoporosis placing her at risk for

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spontaneous fractures/injury." Under the heading "Interventions" it documented, "Give medications as ordered."

On 6/21/13 an interview was conducted at approximately 11:40 a.m. with LPN (licensed practical nurse) #4. When asked why the MAR was blank for 4/17/13, she stated, "The medication was not available that day, I called the pharmacy for the medication and it arrived on the evening of the 17th. I gave it on the 18th in the morning. I forgot to document that it was given".

Review of the "(Name of Pharmacy) Shipping Manifest" dated 4/17/13 documented, "Delivery Date: 4/17/13, Delivery Time 2335 (11:35 p.m.). Resident: (Resident #5); Drug Name: Prolia; QTY (quantity) 1ML." Further review of the manifest documented a check mark under the heading "Received."

On 6/21/13, the Director of Nursing provided this surveyor with a copy of the facility's "Medication or Treatment Error Report" signed by the Unit Manager, RN (registered nurse) #1 dated 6/20/13 and signed by LPN (licensed practical nurse) #4 dated 6/21/13, documented in part: "Medication delivered from pharmacy 4/17/13 after scheduled time. Prolia injection administered on 4/18/13 & nurse failed to document on MAR."

The Administrator and Director of Nursing were made aware of these findings on 6/20/13 at approximately 6:20 p.m.

No further information was provided prior to exit.